THE FUTURE ROLE OF THE NURSE IN GENERAL PRACTICE*

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WE ARE all aware of the impending re-organisation of health and personal social services in Northern Ireland, aimed at producing functional integration of hospital and community services. This is a response to the changing medico-social needs of society. One is also aware of the profound structural changes taking place in primary medical care, based on health centre development. The concept of the primary care team of doctors, nurses and social workers is now accepted and firmly established in some areas, although few social workers are as yet attached to general practice. We have much greater experince of nurse and health visitor attachments. Maybin (1972) states that by 1975 well over 50 per cent of doctors in the province will be practising from health centres, and in the forseeable future this will have risen to at least 70 per cent.

An active interest has been shown recently in the future role of the nurse in general practice and in her relationships with the doctor and other team members. An attempt is made in this paper to define this role and to point out a few relevant problems. Obviously her work will vary in detail from practice to practice and in different areas. There are many variables in general practice, including the size and type of practice, the degree of organisation and specialisation of function and the diversity of professional attitudes. The role of the health nurse or health visitor is easier to define than that of the clinical nurse and will I think be largely unchanged in the future. This paper is mainly concerned with the problems of the latter, who is to be called the community clinical sister in the future. Before defining her role, I wish to comment on the present marked difference of views on:

1. What duties she should perform.
2. By whom she should be employed.
3. To whom she should be responsible.

Reedy (1972a) has fully discussed this diversity of views. It has arisen because of the conflict of interests between the nurse who is attached to a practice by the local authority and the nurse who is employed directly by the general practitioner and paid by him. The latter usually works in small sized primary care units with widely varying terms and conditions of service. Pioneering surveys have been carried out in England which have demonstrated clearly that with suitable training, the practice nurse could assume enhanced clinical responsibilities and develop continuing relationships with the practice patients, which could be a source of valuable information about patient behaviour to the doctor concerned. About the

*A paper read at a Symposium on the Role of the Nurse in General Practice, at the Belfast City Hospital, on 12th November, 1972, organised by the Education Committee of the Northern Ireland Faculty of the Royal College of General Practitioners.

same time, the B.M.A. Charter in 1966 introduced financial incentives to encourage general practitioners to improve their technical and human resources, and they began to group together and enter purpose built premises in increasing numbers. Since then the concept of the primary care team has become firmly established.

Many family doctors, however, accustomed as they have been to small practice units and economy of expenditure, find it difficult to adapt to larger units and to accept specialisation of function within the team. They have always worked with multi-purpose staff and shared out work equally regardless of status or skills. As organisation gets bigger there comes a point at which specialisation of function and a hierarchy of control are necessary for the smooth running of the organisation. This point has now been reached in modern group practice.

Reedy (1972b) comments that the nursing institutions have rightly shown concern about the future of the community clinical sister, who will work under the clinical supervision of the primary care physician. They are worried about her terms and conditions of service, her professional isolation, about study leave and other factors. In a detailed study of 140 practices, Drury and Kuennsberg (1970) found that 85 per cent of practice nurses were used regularly for reception duties and 90 per cent for making appointments. This suggests a waste of professional skills. Against this they reported that 40 per cent of secretary-receptionists tested urines, and 15 per cent did minor surgical dressings. It is evident that there are dangers inherent in this multi-purpose use of staff in small primary care units. With the emphasis on economy of effort and finance the administrative duties are allocated regardless of professional standing.

Terms and conditions of service are probably most advantageous for the nurse, when she is attached after consultation by an enlightened medical officer of health to a group of general practitioners who understand the basic principles of good personnel management. It is essential that the family doctors are consulted and participate in the interview and selection of nursing candidates. Reedy (1972b) believes that the time-work-load saving attributable to such an attachment of a nurse should not be over emphasised. In 1968 the Royal College of General Practitioners reported falling trends in consultation rates between doctor and patient, as the number of items of service carried out by the nurse increased (Royal College of General Practitioners, 1968). It is commonly found that the length of the doctor's day is not reduced in proportion to the nurse or health visitor's contribution, but the quality of practice is greatly improved. This applies particularly to the work of the health visitor.

I believe that the most important aspect of the future role of the nurse will be her capacity to develop continuing and meaningful relationships with patients and feed back valuable information to the doctor. She will, I believe, be used increasingly as the point of first contact in the surgery and home. This implies a role with a higher degree of clinical autonomy than at present. Professor Asa Briggs (D.H.S.S., 1972) has suggested a basic 18 months training period which would lead to the Certificate in Nursing Practice, including experience of hospital and community medicine. A further 18 months course will lead to registration and during it, or following it, nurses may sit for the Higher Certificate of Nursing which will qualify them as specialists in one of the 4 main clinical areas, medical, surgical, psychiatric or community nursing.

Table I illustrates the many technical duties which can be performed by a treatment room nurse in general practice. Tables II and III show the role of the clinical nurse in assessment and treatment. Table IV outlines her general duties. The new post-basic training of the nurse (D.H.S.S., 1972) should enable her to perform these tasks competently.

TABLE I

Technical duties performed by the treatment room nurse in general practice

CLINICAL MEASUREMENTS

BP, temperature, pulse, respiration rate, height and weight.

CLINICAL TESTS

Estimation of E.S.R., Hb
Urinalysis
Chemical test of faeces

COLLECTION OF LABORATORY SPECIMENS

Haematological and biochemical – Venepuncture
Bacteriological – urine, sputum, swabs, etc.
Viral – blood, faeces, throat swabs
Fungal – scrapings
Cytological – cervical cytology

MISCELLANEOUS

Electrocardiography
Vitalograph or peak flow meter
Tonometry
Audiometry (usually performed by health visitor)
Immunisations

TABLE II

The role of the clinical nurse in general practice

A. Screening of casual attenders or emergencies in the treatment room.
B. Assessment of patients in the home on initial and follow-up visits.
C. Follow-up of patients in the surgery (or group clinic) for treatment or surveillance.

TABLE III

The role of the clinical nurse in general practice

Assessment of signs and symptoms

INITIAL HOME VISITS

Minor upper respiratory and alimentary tract infections
Specific infectious diseases
Discharges from hospital
Vague calls for advice
Chronic sick (include geriatric patients)

FOLLOW-UP VISITS

Follow-up of above
Control in cardio-respiratory conditions
Selected mental problems
Rheumatic disorders (lumbago)

CLINICAL SURVEILLANCE OF

Patients requiring dietary supervision (e.g. obesity)
Selected cases of hypertension, or controlled cardiac arrythmias
Mental illness, e.g., depression, schizophrenia, on long term therapy

TREATMENT

Advice to doctor and/or patient

GENERAL

Sub-cutaneous and intra-muscular therapy, dressings, ear-syringing, incision of abscesses, removal of cysts, suture removal, suturing, etc., gynaecological procedures, e.g. cervical smears, changing pessaries

TABLE IV

General duties

Chaperoning patients
Preparing patients for examination
Assisting reception staff with casual attenders
Communicating with hospital and laboratory
Assessing treatment room needs: equipment, dressings, drugs, coats, towels, etc.
Assisting the doctors at examinations and operations
Covering the clinic in the absence of medical staff

In a larger unit some of the technical tasks might be delegated, but it is likely that the future clinical nurse in general practice will continue to do these to strengthen her bonds with patients. General practitioners in turn must learn to delegate case material which the new nurse's training will qualify her to handle. To assign and give authority to the nurse, demands co-ordination of activities and some degree of supervision. Clearly understood criteria governing the work of the nurse must be laid down. She must NOT become a "feldsher" (i.e. an independent inadequately trained doctor).

In 1966 the Terms of Service for General Practitioners in the N.H.S. were revised and formal sanction was given to the general practitioner to delegate work to his professional and lay staff, provided the person was competent to carry out such treatment. Thus in 1971, the Department of Health and Social Security sanctioned the delegation to a nurse of vaccination, but the doctor had to satisfy himself that the nurse had received training in the procedure and was conversant with the requirements for the storage and handling of the vaccine (Reedy 1972 c). The difficulty in the future will be to know how precisely to define the area of clinical activity of the nurse. I repeat again, the aim should be to give the nurse limited clinical autonomy under supervision, and delegation simply implies that the more highly trained doctor accepts that some of his diagnostic and treatment functions can be assigned to and performed competently by his nursing colleague.

Like the general practitioner himself the clinical nurse should work both in the treatment room and in the patient's home. She should have free access to a patient's records, and should herself keep adequate records. Ideally she should have access like the doctor to secretarial help for form filling and letters. The recently published Harvard Davis Report (D.H.S.S., 1971) states "there is a considerable amount of work undertaken at present by the general practitioner which could be delegated to suitably trained nurses and similarly some work could be delegated by highly trained nurses to less highly trained nurses", and so on. Which reminds me of the old adage, "large fleas have small fleas and so add infinitum." Nurses are already being used in a decision making capacity, e.g. in industrial medicine and in the hospital service. The possibility of combining the role of clinical and health nurses was considered, but rejected. It was feared that the demands of curative medicine would take precedence over and detract from the quality and scope of the preventive work. In the future, therefore, it is accepted that the health visitor or community health sister will continue to provide a health education service to families and individuals in the community. The five main aspects of her work are as follows:

1. The prevention of ill health.
2. Early detection and surveillance of high risk groups.
3. Recognition of need and mobilisation of resources.
4. Health teaching.
5. Provision of care; support during stress; advice in illness; and management of children.

One of the great advances in integrating community care services in the past decade has been the reconciliation of health visitors and general practitioners

brought about by attachment to individual practices by enlightened medical officers of health. This has enabled each to understand more fully the role of the other and the professional skills involved. The present generation of medical undergraduates are being given for the first time a much deeper insight into community care and the necessity for a team approach to meet comprehensive medico-social needs. They are being taught to be aggressive, not passive, towards health education and preventive medicine. They are taught the relevance of clinical epidemiology, the use of age-sex registers to identify vulnerable age and sex groups, and have to learn more about human development at all ages. The shift is towards pre-symptomatic detection of illness, and to achieve the clinical aim of early detection of abnormalities, through screening or periodic check-ups, the primary care physician needs the help of his health visitor. She can organise development clinics for infants and young children, immunisation sessions, and help the family doctor to practice preventive geriatric care. She will continue to provide advice and help to mothers before and after their confinements and to their children in infancy and childhood. Owing to the shortage of social workers, I believe the health visitor for many years to come will help the general practitioner to cope with the many common and practice social problems, which arise from day to day. Like the general practitioner she has not the time available to get deeply involved in the long term management of emotional disorders which require counselling and case work techniques of analysis.

We are on the threshold of an administrative reorganisation of the whole National Health Scheme aimed at functional integration of all services under one authority. This will have to be flexible at all levels. There is no room for confusion of views about the future nurse's role and her relationships with other team members nor about her manner of employment or source of authority.

No distinction should be maintained between the practice nurse directly employed by the general practitioner and Area Board nurses attached to a group practice. Harvard Davis's committee (D.H.S.S., 1971) states "we recognise that a separate nurse has suited some practices and nurses but it should not be continued within a unified health service". If Professor Asa Brigg's recommendations (D.H.S.S., 1972) are accepted, it is comforting to realise that nurses in future will be given experience of community nursing as part of both basic and post basic training.

It appears that the nursing service of a group practice will be best supplied in the future by the team of health visitor, clinical nurse, and enrolled nurse supported by ancilliary nursing help as required. Apart from her nursing duties the distinction between being a technical assistant or a professional colleague in the future lies in the degree to which the general practitioner is prepared to delegate and give the clinical nurse limited clinical autonomy, which must be limited to clearly defined areas, apart from which she works under supervision. The danger of the clinical nurse merging into an inadequately trained primary physician – a feldsher – must be constantly borne in mind.

References

D.H.H.S., Welsh Office (1971). *Report of a Sub-committee of the Standing Medical Advisory Committee.* H.M.S.O., London.

D.H.H.S. (1972). *Report of the Committee of Nursing.* Cmnd. 5115. H.M.S.O., London.

MAYBIN, R. P. (1972). *J. Roy. Coll. Gen. Practit.*, **22**, 365.

DRURY,, M., and KEUNSSBERG, E. V. (1970). *Brit. med. J.*, **4**, 42.

Royal College of General Practitioners (1968). *Reports from General Practice, No.* 10, *'The Practice Nurse'.* London.

REEDY, B. L. E. C. (1972, a). *Update*, **5**, 366.

REEDY, B. L. E. C. (1972, b). *Update*, **5**, 75.

REEDY, B. L. E. C. (1972, c). *Update*, **5**, 433.